UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

AMPYRA (dalfampridine)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO (801) 536-0477

CRITERIA:

- Minimum age requirement: 18 years old.
- Documented diagnosis of Multiple Sclerosis.
- No history of seizures.
- No history of moderate to severe renal impairment, as evidenced by a creatinine clearance rate greater than or equal to 51mL/min.

AUTHORIZATION:

Initial authorization will be granted for one year.

RE-AUTHORIZATION:

Updated letter of medical necessity including no seizures and current renal function greater than or equal to 51ml/min.

8/26/10

http://health.utah.gov/medicaid/pharmacy